FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0015784

Facility Name: Walnut Manor

Address: 308 South Second Street (Number) Walnut (City) 61376 (Zip Code)

County: Bureau

Telephone Number: (815)379-2131 **Fax #** (815)379-2235

IDPA ID Number: 36 27394 92001

Date of Initial License for Current Owners: 07/13/73

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Monica Robbins **Telephone Number:** (815)875-4541

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/99 to 09/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Dennis L. Grobe
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) See Independent Auditor's Report attached
(Firm Name & Address) Clifton Gunderson, L.L.C.
123 South Pleasant, Princeton, IL 61356
(Telephone) (815)875-4541 Fax # (815)872-0827

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	62	Intermediate (ICF)	62	22,692	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	62	TOTALS	62	22,692	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	9,899	11,169		21,068	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,899	11,169		21,068	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.84%

D. How many bed-hold days during this year were paid by Public Aid?
34 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 07/30/73

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/00 Fiscal Year: 9/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	132,805	22,817	6,719	162,341		162,341		162,341			1
2	Food Purchase		126,585		126,585		126,585	(9,156)	117,429			2
3	Housekeeping	46,312	4,049		50,361		50,361		50,361			3
4	Laundry	57,058	11,288	1,461	69,807		69,807		69,807			4
5	Heat and Other Utilities			59,027	59,027		59,027	(4,939)	54,088			5
6	Maintenance	26,916	8,912	18,671	54,499		54,499	3,443	57,942			6
7	Other (specify):*											7
8	**TOTAL General Services**	263,091	173,651	85,878	522,620		522,620	(10,652)	511,968			8
	B. Health Care and Programs											
9	Medical Director			750	750		750		750			9
10	Nursing and Medical Records	769,638	51,108	37,183	857,929		857,929		857,929			10
10a	Therapy											10a
11	Activities	36,181	2,710	5,495	44,386		44,386		44,386			11
12	Social Services	16,897			16,897		16,897		16,897			12
13	Nurse Aide Training	718		150	868		868		868			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	823,434	53,818	43,578	920,830		920,830		920,830			16
	C. General Administration											
17	Administrative	46,221			46,221		46,221		46,221			17
18	Directors Fees			3,920	3,920		3,920		3,920			18
19	Professional Services			25,939	25,939		25,939		25,939			19
20	Dues, Fees, Subscriptions & Promotions			11,757	11,757		11,757	(3,249)	8,508			20
21	Clerical & General Office Expenses	24,840	6,316	16,060	47,216		47,216	(65)	47,151			21
22	Employee Benefits & Payroll Taxes			232,587	232,587		232,587		232,587			22
23	Inservice Training & Education			1,032	1,032		1,032		1,032			23
24	Travel and Seminar			3,912	3,912		3,912	(2,513)	1,399			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			14,400	14,400		14,400		14,400			26
27	Other (specify):*			5,864	5,864		5,864	(5,864)				27
28	**TOTAL General Administration**	71,061	6,316	315,471	392,848		392,848	(11,691)	381,157			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,157,586	233,785	444,927	1,836,298		1,836,298	(22,343)	1,813,955			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Walnut Manor #0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			58,389	58,389		58,389	(22,525)	35,864			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,646	42,646		42,646	(33,551)	9,095			32
33	Real Estate Taxes			38,220	38,220		38,220	(7,620)	30,600			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			139,255	139,255		139,255	(63,696)	75,559			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	10,838	913	295	12,046		12,046	(12,046)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,038	34,038		34,038		34,038			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	10,838	913	34,333	46,084		46,084	(12,046)	34,038			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,168,424	234,698	618,515	2,021,637		2,021,637	(98,085)	1,923,552			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,313)	2		4
5	Telephone, TV & Radio in Resident Rooms	(65)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,235	30		9
10	Interest and Other Investment Income	(307)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(332)	2		13
14	Non-Care Related Interest	(32,656)	32		14
15	Non-Care Related Owner's Transactions	(28,714)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(588)	32		18
19	Entertainment	(2,513)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,654)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(29,132)	var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (98,039)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(46)	var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (46)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (98,085)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Walnut Manor

ID# 0015784

Report Period Beginning: 10/01/99

Ending: 09/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber and beauty	$ (12,046)	40	1
2	Food (vending machine expense)	(1,511)	2	2
3	Dues, fees, subscriptions and promotions -			3
4	(sales tax on nonfood items)	(595)	20	4
5	Repairs (deferred expense adjustment)	3,443	6	5
6	Non-care real estate taxes - Independent Living Center	(7,620)	33	6
7	Non-care heat and other utilities-Ind Living Center	(4,939)	5	7
8	Other non-care general and administrative-Ind Liv Cent	(5,864)	27	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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78				78
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80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(29,132)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,156)	0	0	0	0	0	0	0	0	0	0	(9,156)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,939)	0	0	0	0	0	0	0	0	0	0	(4,939)	5
6	Maintenance	3,443	0	0	0	0	0	0	0	0	0	0	3,443	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,652)	0	0	0	0	0	0	0	0	0	0	(10,652)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,249)	0	0	0	0	0	0	0	0	0	0	(3,249)	20
21	Clerical & General Office Expenses	(65)	0	0	0	0	0	0	0	0	0	0	(65)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,513)	0	0	0	0	0	0	0	0	0	0	(2,513)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(5,864)	0	0	0	0	0	0	0	0	0	0	(5,864)	27
28	**TOTAL General Administration**	(11,691)	0	0	0	0	0	0	0	0	0	0	(11,691)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,343)	0	0	0	0	0	0	0	0	0	0	(22,343)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walnut Manor # 0015784 **Report Period Beginning:** 10/01/99 **Ending:** 09/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(22,479)	(46)	0	0	0	0	0	0	0	0	0	(22,525)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(33,551)	0	0	0	0	0	0	0	0	0	0	(33,551)	32
33	Real Estate Taxes	(7,620)	0	0	0	0	0	0	0	0	0	0	(7,620)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(63,650)	(46)	0	0	0	0	0	0	0	0	0	(63,696)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(12,046)	0	0	0	0	0	0	0	0	0	0	(12,046)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(12,046)	0	0	0	0	0	0	0	0	0	0	(12,046)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(98,039)	(46)	0	0	0	0	0	0	0	0	0	(98,085)	45

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Walnut Community Development Corp.	Walnut, IL	not for profit organization

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation-see attached	$ 46	Walnut Community Development Corporation		$	$ (46)	1
2	V		schedule for explanation						2
3	V		and calculation						3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 46			$	$ * (46)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Thomas Garland	President	Board Member	1.11%	0	see Note		Board Mtgs	$ 560	18,8	1
2	Tony Zueger	Vice President	Board Member	3.33%	0	see Note		Board Mtgs	540	18,8	2
3	L. Allen Wallace	Treasurer	Board Member	2.22%	0	see Note		Board Mtgs	300	18,8	3
4	V. Brooke Haurberg	Director	Board Member	5.55%	0	see Note		Board Mtgs	520	18,8	4
5	Dennis L. Grobe	Director/Admin.	Board Member	1.11%	0	40-50	100.00%	Bd Mtg/Admin	46,821	18,8 & 17,1	5
6	Lynn A. Anderson	Director	Board Member	4.44%	0	see Note		Board Mtgs	580	18,8	6
7	L. Bruce Atherton	Director	Board Member	1.11%	0	see Note		Board Mtgs	580	18,8	7
8	Steve Schlumpf	Director	Board Member	0.00%	0	see Note		Board Mtgs	240	18,8	8
9											9
10	Note: Board Meetings are held		Schedule V, line 17, column 1		46,221						10
11	monthly and are approximately		Schedule V, line 18, column 8		3,920						11
12	two hours in duration		AGREES TO TOTAL		50,141						12
13								TOTAL	$ 50,141		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Walnut Comm. Development	X		operating		various	70,000	85,000	on demand	7.5000	6,092	6
7	Citizens First State Bank		X	revolving line of credit		various		97,200	on demand	10.5000	3,310	7
8												8
9	TOTAL Facility Related						$ 70,000	$ 182,200			$ 9,402	9
	B. Non-Facility Related*											
10	Citizens First State Bank		X	Independent Living Center	$3,074.00	6/26/98	438,580	430,124	6/20/28	8.2500	32,656	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$3,074.00		$ 438,580	$ 430,124			$ 32,656	14
15	TOTALS (line 9+line14)						$ 508,580	$ 612,324			$ 42,058	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	28,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	35,591	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,091	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	31,129	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	38,220	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	29,560	8
	1996	30,664	9
	1997	30,898	10
	1998	34,610	11
	1999	35,591	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

2000 RE tax accrual calculation:
35,591 x 1.10 = 39,150
39,150 x 3/4 year = 29,362 approximation - using $31,129 2000 accrual

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,000 B. General Construction Type: Exterior _____ Frame Non-combustible Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Independent Living Center
type of business - apartments
square footage - 7,200
# of beds/units available - 8 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	for building home	609,840	1973	$ 15,000	1
2	for building home	15,115	1979	5,610	2
3	TOTALS	624,955		$ 20,610	3

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62			1973	$ 413,050	$ 10,326	40	$ 10,326	$	$ 280,239	4
5	Concrete rep			1979	1,116		20			863	5
6	Roof repairs			1979	1,000		20			799	6
7	Roof repairs			5/13/1993	15,263		25	611	611	4,888	7
8	Roof repairs			7/15/1994	39,041		25	1,562	1,562	9,763	8
	Improvement Type**										
9	Fire doors			1977	1,605	40	40	40		940	9
10	Screens			1979	15		3			15	10
11	Improvements - lights			1978	3,737		10			3,737	11
12	Railing, remodeling			Nov-79	1,598		10			1,598	12
13	Remodeling & carpet			1980	11,364		5			11,364	13
14	Remodeling, lights & drapes			1981	6,721		10			6,721	14
15	Remodeling, lights & drapes			1982	2,572		10			2,572	15
16	Lights - parking lot			Jan-83	335		15			335	16
17	Utility room			Aug-83	1,059		15			1,059	17
18	Door - shower remodeling			Feb-84	387		15			387	18
19	3 humidifiers			Mar-84	1,608		10			1,608	19
20	Drapes			Jun-84	2,395		5			2,395	20
21	Furnaces			May-84	4,028	201	15		(201)	4,007	21
22	Wind break			Feb-84	1,650		15			1,650	22
23	Shower room tile			Oct-84	412	21	20	21		336	23
24	Door replacement			Nov-84	663	33	15	6	(27)	663	24
25	Divider door			Dec-84	1,074	54	15	6	(48)	1,074	25
26	Bath, remodel, etc.			Jul-85	450	23	15	22	(1)	450	26
27	Storage garage			Aug-88	6,911	219	20	346	127	4,325	27
28	Shower walls & tile			May-91	3,950		10	263	263	2,499	28
29	Lubical draperies			May-91	8,260		10	43	43	8,216	29
30	Air conditioner			Jun-91	2,639		10	264	264	2,508	30
31	Air conditioner unit			Sep-91	413		10	41	41	390	31
32	Carpet			Nov-91	12,100		10	1,210	1,210	10,285	32
33	Cabinet			Jan-92	161		15	11	11	93	33
34	Interior improvements			Jun-92	500		15	33	33	281	34
35	CONTINUED ON NEXT PAGE										35
36	TOTAL (lines 4 thru 35)				$ 546,077	$ 10,917		$ 14,805	$ 3,888	$ 366,060	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wall improvements			Jul-92	1,066		10	107	107	909	9
10	Improvements			Aug-92	2,733		15	182	182	1,547	10
11	Drapes, sheer rods			Sep-92	12,035		10	1,204	1,204	10,300	11
12	Piping water heater			1/31/1993	980	44	15	65	21	478	12
13	Smoke & fire damper			5/26/1993	3,358	150	15	224	74	1,680	13
14	TV tower			10/30/1992	436	19	10	44	25	330	14
15	Ceiling work			7/26/1993	2,086	53	15	139	86	1,043	15
16	Roof walk			1/8/1993	1,060	34	25	42	8	315	16
17	Interior improvement			8/15/1993	500	22	15	33	11	248	17
18	Drapes, sheers & rods			5/31/1994	3,823	338	10	382	44	2,435	18
19	Wall & interior improvements			1/3/1994	8,513	756	15	568	(188)	3,763	19
20	Telenurse 8000 system			3/9/1995	12,450	1,111	15	830	(281)	4,565	20
21	5 ton condensing unit			8/21/1995	1,980		15	132	132	726	21
22	Chair rail, cabinet			4/16/1996	6,870		10	687	687	3,092	22
23	Tile			4/12/1996	1,131		10	113	113	509	23
24	Door frames			9/5/1996	2,345	60	39	60		242	24
25	Cabinets & countertops			Sep-98	4,228	740	10	282	(458)	599	25
26	Bathroom remodeling			Mar-99	8,243	211	15	550	339	825	26
27	Med Room improvements			Apr-99	4,922	126	15	328	202	492	27
28	Wander Guard system			Mar-00	760	136	10	38	(98)	38	28
29	Fire alarm system			Mar-00	675	121	10	34	(87)	34	29
30	Main entrance door alarm			Mar-00	2,422	34	10	121	87	121	30
31											31
32											32
33											33
34											34
35	CONTINUED ON NEXT PAGE										35
36	TOTAL (lines 4 thru 35)				$ 82,616	$ 3,955		$ 6,165	$ 2,210	$ 34,291	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Walks, parking area			1973	22,000		15			22,000	9
10	Dikes, water gates			1976	1,055		20			1,055	10
11	Trees			1978	73		10			73	11
12	Shrub			1980	48		10			48	12
13	Parking area			1982	1,616		5			1,616	13
14	Grading & gravel			Nov-82	1,330		15			1,330	14
15	Shrubs			Oct-83	213		10			213	15
16	Parking lot			Dec-84	11,880	594	15	66	(528)	11,814	16
17	Blacktopping storage area			Sep-88	400	13	15	27	14	337	17
18	New patio			May-95	6,998	467	15	467		2,569	18
19	Edging around patio			Aug-95	1,737	116	15	116		638	19
20	Retention pond, drains			Jul-97	7,565	504	15	504		1,575	20
21											21
22											22
23											23
24	Fixed equipment at 10/77			Oct-77	50,530		13 avg			50,530	24
25	Sprinkler and other			Dec-77	3,253		15 avg			3,253	25
26	Water heater and fans			Nov-78	1,207		13 avg			1,207	26
27	Smoke detectors			1982	105		5			105	27
28	Fans, ceiling			Dec-83	310		15			310	28
29	Water heaters - 2			Jul-85	873		15	46	46	873	29
30	Plaques			Nov-84	234		10			234	30
31	Smoke detectors - 3			May-86	570		5			570	31
32	Toilets			Jul-87	185		20	9	9	120	32
33	Air conditioner compressor			Sep-87	1,626		10			1,563	33
34	Door holders - 2			May-88	575		15	38	38	475	34
35	CONTINUED ON NEXT PAGE										35
36	TOTAL (lines 4 thru 35)				$ 114,383	$ 1,694		$ 1,273	$ (421)	$ 102,508	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Door alarm system			Jun-89	2,796	233	20	140	(93)	1,610	9
10	Heater/air conditioner unit - lounge			Nov-88	616	51	15	41	(10)	471	10
11	Water softener			Apr-90	3,000		15	200	200	2,100	11
12	Nine smoke detectors			Sep-90	1,206		5			1,203	12
13	Furnace			Sep-90	5,978		15	399	399	4,189	13
14	Furnace			May-91	1,253		15	84	84	798	14
15	Fire alarm panel			Jun-91	1,940		15	129	129	1,226	15
16	Water heater			Nov-93	3,000		15	200	200	1,375	16
17	Air conditioner			Jul-94	1,265		15	84	84	515	17
18	Water heater/access			Sep-94	7,679	670	15	512	(158)	3,136	18
19	Cabinets			Aug-98	3,647	638	10	365	(273)	776	19
20	Bathroom fixtures and doors			Feb-99	18,379	4,501	15	1,225	(3,276)	1,838	20
21	Doors and cabinets			Apr-99	4,900	1,200	15	327	(873)	491	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 55,659	$ 7,293		$ 3,706	$ (3,587)	$ 19,728	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 216,501	$ 4,998	$ 9,488	$ 4,490		$ 171,899	37
38	Current Year Purchases	6,200	818	473	(345)		473	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 222,701	$ 5,816	$ 9,961	$ 4,145		$ 172,372	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Transport residents	Ford 350 Van	Dec-89	$ 32,704	$	$	$	5	$ 32,704	42
43										43
44										44
45										45
46	TOTALS			$ 32,704	$	$	$		$ 32,704	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,074,750	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 29,675	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 35,910	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 6,235	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 727,663	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Independent Living Center	$ 595,532	$ 28,714	$ 84,879	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 595,532	$ 28,714	$ 84,879	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 20

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 10

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)	96	382		478
4	Clinical Wages (b)		240		240
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	100	50		150
8	Nurse Aide Competency Tests				
9	TOTALS	$ 196	$ 672	$	$ 868
10	SUM OF line 9, col. 1 and 2 (e)	$ 868			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,249	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	113,646		3
4	Supply Inventory (priced at)	11,706		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,783		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): income tax refund receivable	5,250		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 146,634	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,000		12
13	Land	20,610		13
14	Buildings, at Historical Cost	776,278		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	221,442		16
17	Accumulated Depreciation (book methods)	(876,299)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): see attached	609,532		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 754,563	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 901,197	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 24,038	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	190,867		29
30	Accrued Salaries Payable	24,910		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,246		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,129		32
33	Accrued Interest Payable	1,097		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Independent Living Center liabilities	22,102		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 308,389	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	425,302		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 425,302	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 733,691	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 167,506	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 901,197	$	48

***(See instructions.)**

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 259,956	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 259,956	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(70,275)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(11,935)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **shares redeemed - 40 shares common stock**	(10,240)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (92,450)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 167,506	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,027,874	1
2	Discounts and Allowances for all Levels	(168,177)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,859,697	3
	B. Ancillary Revenue		
4	Day Care	48,800	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 48,800	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	12,343	13
14	Non-Patient Meals	7,313	14
15	Telephone, Television and Radio	65	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 19,721	23
	D. Non-Operating Revenue		
24	Contributions	2,077	24
25	Interest and Other Investment Income***	306	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,383	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machines	1,511	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,511	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,932,112	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	522,620	31
32	Health Care	920,830	32
33	General Administration	392,848	33
	B. Capital Expense		
34	Ownership	139,255	34
	C. Ancillary Expense		
35	Special Cost Centers	12,046	35
36	Provider Participation Fee	34,038	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,021,637	40
41	**Income before Income Taxes (line 30 minus line 40)****	(89,525)	41
42	**Income Taxes**	19,250	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (70,275)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,880	2,080	$ 39,423	$ 18.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,196	12,095	178,944	14.79	3
4	Licensed Practical Nurses	10,491	11,330	153,407	13.54	4
5	Nurse Aides & Orderlies	44,055	47,122	397,865	8.44	5
6	Nurse Aide Trainees	121	121	718	5.93	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,863	2,119	21,641	10.21	9
10	Activity Assistants	2,065	2,257	14,540	6.44	10
11	Social Service Workers	2,059	2,259	16,896	7.48	11
12	Dietician					12
13	Food Service Supervisor	1,990	2,206	21,454	9.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,121	17,295	111,351	6.44	15
16	Dishwashers					16
17	Maintenance Workers	2,898	3,099	26,916	8.69	17
18	Housekeepers	7,470	7,820	46,312	5.92	18
19	Laundry	9,442	10,229	57,058	5.58	19
20	Administrator	2,000	2,080	46,221	22.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,189	2,365	24,840	10.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Barber&Beauty	1,828	1,852	10,838	5.85	33
34	TOTAL (lines 1 - 33)	117,668	126,329	$ 1,168,424 *	$ 9.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	98	$ 4,410	1,3	35
36	Medical Director	15	750	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	50	650	10,3	39
40	Physical Therapy Consultant	65	2,962	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	455	10,3	43
44	Activity Consultant	25	1,332	11,3	44
45	Social Service Consultant	51	2,642	11,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	314	$ 13,201		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,569	31,087	10,3	52
53	TOTAL (lines 50 - 52)	1,569	$ 31,087		53

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dennis Grobe	Administrator	1.11%	$ 46,221
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 46,221

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Clifton Gunderson LLC	audit & accounting	$ 17,931
Creative Solutions	software service fees	2,262
Duane, Morris & Heckscher	legal	5,746
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 25,939

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,926
Unemployment Compensation Insurance	11,376
FICA Taxes	89,797
Employee Health Insurance	100,098
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee physicals	390
TOTAL (agree to Schedule V, line 22, col.8)	$ 232,587

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,561
Health Care Worker Background Check	432
(Indicate # of checks performed 36)	
Public Relations	2,654
Various dues and subscriptions	4,502
Annual Report fee	115
Various licenses and fees	898
Sales Tax	595
Less: Sales Tax	(595)
Less: Public Relations Expense	(2,654)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,508

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	755
Seminar Expense	644
Entertainment Expense	2,513
Other unallowable travel	
Entertainment Expense	(2,513)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,399

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/99 Ending: 09/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Acoustical ceiling	10/94	$ 7,175	10	$ 718	$ 718	$ 718	$ 718	$ 718	$ 718	$ 718	$ 718	$ 354
2	Soffits/gutter repair	6/95	9,839	10	984	984	984	984	984	984	984	984	491
3	Wallcovering	2/96-9/96	8,705	5	1,741	1,741	1,741	1,741	870				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 25,719		$ 3,443	$ 3,443	$ 3,443	$ 3,443	$ 2,572	$ 1,702	$ 1,702	$ 1,702	$ 845

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Health Care Association $2,534**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **9,700** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **34,038**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **NONE**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **NONE** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **7,313**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **28%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **no personal use of company vehicle**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Clifton Gunderson L.L.C.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **YES** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.